STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G221	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	1639 ROXANNA ROAD, NW WASHINGTON, DC 20012

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 30, 2010 through July 2, 2010. A sample of three clients was selected from a population of five females with varying degrees of intellectual disabilities. While assessing the facility's incident managment system, the surveying team reviewed an incident where Client #1 was transported to a local hospital's emergency room for evaluation after complaining of not feeling well and having elevated blood sugar and a low blood pressure. A review of the intemal investigation revealed that the client died shortly after arriving to the emergency room. Due to the nature of this incident and due to the facility's failure to report the incident to the SSA, an investigation commenced on July 1, 2010 and was completed on July 2, 2010. This survey/investigation was initiated utilizing the fundamental process; however, due to concerns in the area healthcare, the process was extended on July 1, 2010, at approximately 12:50 p.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Health Care Services and Client Protection. The extension led to the determination that the facility's nursing practice posed an immediate and serious threat to clients residing in the facility. The agency's administrator and the Director of Nursing (DON) were notified on the same at approximately 2:23 p.m. of the Immediate Jeopardy (IJ) to client's health and safety. The IJ was lifted later that day, at approximately 7:40 p.m., after the facility submitted a credible plan of action to address the client's immediate, short	W 000	The administration at MarJul Homes recognizes the importance of exercising general policy, budget, and operating direction over the facility. Because we recognize the need for extensive training for all staff, we have hired a Quality Assurance/Trainng Specialist, who will coorindate and monitor all required and mandated trainings. To further ensure the health and safety of our individuals, the agency has hired a new Director of Nursing who will oversee all medical policy and procedures and decisions. A new Primary Care Physician has been hired to oversee and treat all medical needs of the indivudals and to communicate with the Director of Nursing. In addition, we are in the process of updating our policy and procedures manual. All of our efforts are being put in place to ensure the highest quality of care for the individuals served by MarJul Homes. Received 7/26/10 GOVERNMENT OF THE DISTRICT OF CDLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	7/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia Towson — TITLE: Executive Director — (X6) DATE: 7-26-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1	W 000		

term and long term safety outlined below:

1. A Management of Medical Emergencies Protocol describing instructions for emergency instructions will be developed immediately.

2. Staff training on above Management of Medical Emergencies Protocol will occur immediately.

3. All staff will be trained on Management of Medical Emergencies Protocol within 24 hours with the first training to begin today (7/1/2010). As of 7:35 p.m. on 7/1/2010 all staff have been trained on this protocol. All staff will be trained weekly x 4 weeks, then monthly x 4, then quarterly.

4. The Licensed Practical Nurses (LPN) that were identified have been removed from active duty and will receive training and be required to demonstrate competency on the following (7/2/2010) prior to returning to active status. A Pre / Post test will be administered. The LPN's will be trained weekly x 4 weeks, then monthly x 4, then quarterly.

a. Management of Emergency Medical Conditions

b. Assessment of Medical Status, Abnormal Conditions

c. Identifying an Emergency

d. Notification / Follow Up of Emergencies

e. Documentation

5. A monitoring tool will be developed and

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W 000	Continued From page 2 implemented to ensure that assessments and follow up services are being completed / documented. Monitoring frequency will begin at every other day and be decreased as competency /completion is demonstrated. 6. Health Management Care Plan's will be reviewed / updated and training of all staff will occur within 72 hours. 7. A Policy establishing RN assessment of all individuals with changes in medical status to occur within 24 hours based on individual's needs (stability) will be implemented. The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports. As a result, the facility was deemed in non-compliance with the Conditions of Participation in the areas of Client Protections and Health care services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the governing body failed to ensure effective operating direction to maintain the health and safety of five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5) The findings include: 1. Cross refer to W127. The Governing Body failed to ensure that systems were designed and implemented to make certain clients were not	W 104	1. The administration at MarJul Homes recognizes the need for systems to be in place to prevent abuse and neglect of the served individuals. Agency-wide abuse and neglect trainings will occur on all shifts, monthly x 4, and quarterly thereafter. See Attachment #3	7/23/10

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W 104	Continued From page 3 subjected to neglect. 2. Cross refer to W140. The Governing Body failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds. 3. Cross refer to W148. The Governing Body failed to promptly notify the client's family members/legal guardians of injuries of unknown origin. 4. Cross refer to W149. The Governing Body failed to ensure that its incident management policies and procedures were implemented and failed to develop policies and procedures to address medical emergencies and there by preventing neglect. 5. Cross refer to W153. The Governing Body failed to ensure that all allegations of neglect and injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely. 5. Cross refer to W154. The Governing Body failed to ensure all incidents were thoroughly investigated. 6. Cross refer to W331. The Governing Body facility failed to provide timely and appropriate nursing services with posed an immediate risk to Client #1's health and safety.	W 104	2. The administration of MarJul Homes will ensure that all staff are trained on the agency's policy-"Safeguarding Individual Funds and Posessions Policy" The QMRPs and House Mangers will be retrained on the policy. They will then be responsible for training their staff. Monthly monitoring by the Executive team will occur on the third Tuesday of the month following the weekly adminstrative meeting. See Attachment #4 3. Staff will be retrained on the incident management system. The training will cover the importance of notifying the client's family/ guardians, the Department of Health, and all other required entities of all incidents and injuries of unknown orgins. 4. See W 331 See Attachment #5 5. See W104. 5 a. The Quality Assurance Specialist will ensure that all incidents are investigated per the company's incident management policy. Incident Management will now be discussed at the weekly Administrative Meeting and the Indicent Management Committee will review all incidents monthly for prevention and for analyzing the trends.	7/28/10 7/27/10 7-23-10 7/27/10
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122	See W 331 See Attachment #6	7-23-10

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W 122	Continued From page 4 This CONDITION is not met as evidenced by: Based staff interviews and record review, the facility failed to ensure that a system had been implemented to maintain a complete accounting of clients' personal funds [See W140]; failed to promptly notify the client's family members/legal guardians of neglect and injuries of unknown origin [See W148]; failed to ensure that its incident management policies and procedures were implemented and failed to develop policies and procedures to address medical emergencies thereby preventing neglect [See W149]; failed to ensure that all allegations of neglect and injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely [See W153]; and failed to thoroughly investigate all injuries of unknown origin and/or incidents of neglect [See W154]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	W 122	The administration at MarJul Homes recognizes that practices to protect the the individuals and ensure their health and safety are of paramount importance. Policy and proceedures have been revised and ongoing trainings will be conducted for consistent implementation. The Director of Nursing has developed and trained all staff on 1) Managment of Emergencey Medical Conditions and 2) Protocol for Emergency Transport. See Attachment # 5	7/1/10
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to make certain clients were not	W 127	Training on Abuse and Neglect was conducted on 7/1/10 by the Director of Nursing. Ongoing Abuse and Neglect training will occur monthly x 4 and then quarterly. See Attachment #3	7-26-10

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W 127	Continued From page 5 subjected to neglect for one of three clienst included in the sample. (Client #1) The findings include: Cross refer to W331. On July 1, 2010 surveyors identified an immediate jeopardy to clients health and safety. At approximately 2:23 p.m., the facility's administrator was notified by telephone that the safety concerns of the nursing services provided to Client #1 posed an immediate jeopardy to the other client's in the home. At the time of the survey the facility failed to ensure that systems were designed and implemented to make certain clients were not subjected to neglect.	W 127		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for two of the five clients residing in the facility. (Clients #3 and #4) The findings include: 1. On July 2, 2010, at approximately 3:20 p.m., interview with the qualified mental retardation professional (QMRP) and review of the client's financial records revealed that the facility assisted the client's with maintaining her finances.	W 140	1. The administration of MarJul Homes will ensure that all staff are trained on the agency's policy-"Safeguarding Individual Funds and Posessions Policy" The QMRPs and House Mangers will be retrained on the policy. They will then be responsible for training their staff. Monthly monitoring by the Executive team will occur on the third Tuesday of the month following the weekly adminstrative meeting. The QMRP at the time of the withdrawal is no longer at MarJul Homes. Any unaccounted funds will be returned to the individual's account. See Attachment #4	7/26/10

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W 140	Continued From page 6 Review of Client #3's bank statement dated April 2, 2010, revealed a withdrawal in the amount of $300.00. Further review of the client's financial records failed to provide receipts for the aforementioned withdrawal/expenditure from Client #3's personal account. This was acknowledged through interview with the QMRP on the same day at approximately 3:35 p.m. At the time of the survey, the facility failed to ensure a complete accounting of the client's personal funds by proving evidence that justified the aforementioned withdrawal. 2. Interview with the QMRP on July 2, 2010, at approximately at 3:45 p.m., and review of Client #4's financial record, revealed that the facility assisted the client with maintaining her finances. Review of the Client #4's records revealed 300.00 was withdrawn from her account on April 8, 2010, and 50.00 was withdrawn from her account on May 7, 2010. Further review of the client's financial records failed to provide receipts for the aforementioned withdrawal/expenditure from Client #3's personal account. This was acknowledged through interview with the QMRP on the same day at approximately 4:00 p.m. At the time of the survey, the facility failed to ensure a complete accounting of the client's personal funds by proving evidence that justified the aforementioned withdrawal.	W 140	2. See W 140. 1 Attachment #4	7-26-10
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse,	W 148	See W 104, #3. See Attachment #1	7-26-10

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W 148	Continued From page 7 or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the client's family members/legal guardians of injuries of unknown origin for one of three clients included in the sample. (Client #1) The findings include: On June 30, 2010, at approximately 1:45 p.m., interview with qualified mental retardation professional (QMRP) revealed Client #1 had a legal guardian that was involved in her habilitation and care. Review of the facility's incident reports and corresponding investigations on June 30, 2010, beginning at 1:52 p.m., and review of Client #1's nursing notes on July 1, 2010, at approximately 10:00 a.m., revealed the facility failed to provide evidence that Client #1's legal guardian and/or family members were made aware of the following incidents: - An incident report and nursing progress note dated August 3, 2010 revealed Client #1 stated to the PM Nurse that she had fallen out of the van. The nurse assessment revealed Client #1 had broken skin to both of her knees. - An incident report and nursing progress note dated October 18, 2009 revealed Client #1 informed the nurse that she had a bruise on her stomach. The nurse observed a bruised area on the lower side of the client's abdomen.	W 148		

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W 148	Continued From page 8 - An incident report and nursing progress note dated April 10, 2010 revealed Client #1 showed the PM Nurse her left hand, 3rd finger which was bruised. Interview with the Nurse Coordinator on July 2, 2010, at approximately 4:00 p.m., acknowledged that that Client #1's guardian was not made aware of the above aforementioned incidents. At the time of the survey, the facility failed to provide evidence that the legal guardians and/or family members of Client #1 were made aware of the aforementioned incidents.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies to ensure the health and safety for five of five clients included in the sample. (Clients #1, #2, #3, #4 and #5) The findings include: 1. The facility failed to ensure the Department of Health (DOH) was notified timely of significant incidents (neglect and injuries of unknown origin) in accordance with federal regulations and state law. Cross refer to W331. The facility failed to develop policies and procedures to address medical	W 149	See W 331	7-23-10

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W 149	Continued From page 9 emergencies thereby preventing neglect. During a face to face interview with the Director of Nursing (DON) on July 1, 2010, at approximately 1:30 p.m., the DON acknowledged that a written policy had not been developed to address the management of medical emergencies protocol nor had any emergency protocol been developed describing instructions for emergency instructions. 2. The facility failed to ensure staff implemented their written policies and procedures for reporting of injuries of unknown origin. Cross refer to W153. Review of the facility's incident and investigation reports on June 6, 2010, beginning at 1:52 p.m., revealed evidence of four incidents of injuries of unknown origin that were documented in the nurse's progress notes and incident reports. Continued review of the facility's incident reports failed to show evidence that the administrator and the Department of Health (DOH) were informed the aforementioned incidents. Interview with the Nurse Coordinator (NC) was conducted on July 2, 2010, at approximately at 4:00 p.m. She indicated that staff who witnessed, discovered or were informed of the aforementioned incidents should have immediately documented the incidents on an incident report form, before the end of the shift. Review of the facility's incident management policy (IMP) on July 2, 2010, revealed that incidents were categorized into both reportable and serious reportable incidents. Deaths, allegations of abuse, neglect and injuries of unknown source were identified as serious	W 149	2. See W 104 #3.	7-28-10

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W 149	Continued From page 10 reportable incidents. According to the policy, staff were required to "immediately report" the serious reportable incidents to the case manager, DOH, and the client's parent or guardian for all serious reportable incidents. Incident report forms were to be completed on "all serious reportable incidents" and the incident report was to be forwarded to the DOH within 24 hours. Review of the facility's incident reports; however, revealed that the facility had not notified their administrator and the State agency of incidents, as required. 3. Cross refer to W148. The facility failed to implement its written policy regarding the notification of guardians and/or family members of serious reportable incidents (i.e. injuries of unknown origin) as evidenced below. On June 30, 2010, at approximately 1:45 p.m., interview with Qualified Mental Retardation Professional (QMRP) revealed Client #1 had a legal guardian that was involved in her habilitation and care. Review of the facility's incident reports on June 30, 2010 at approximately 1:52 p.m. and Client #1's nursing progress notes on July 1, 2010 at approximately 10:00 a.m. revealed the facility failed to provide evidence that Client #1's legal guardian and/or family members of were informed of all significant incident. Review of the facility's incident management policy (IMP) on July 2, 2010, at approximately 4:10 p.m., revealed staff were required to "immediately call" the case manager, DOH, and the client's parent or guardian for all serious reportable incidents.	W 149	3. See 104 #3.	7-26-10

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W 149	Continued From page 11 4. Cross-Refer to W154. The facility failed to thoroughly investigate significant incidents (injuries of unknown origin) in accordance with their incident management policy. Review of the incidents reports on June 30, 2010 at approximately 1:52 p.m. and Client #1's nursing progress notes on July 1, 2010 at approximately 10:00 a.m. revealed three injuries of unknown origin were not investigated. Review of the incident management policy on July 2, 2010, at approximately 4:15 p.m., revealed the agency will provide evidence that all alleged violations are thoroughly investigated.	W 149	4. The administration of MarJul Homes will ensure that all incidents are investigated according to the agency's incident management policy. All incidents will be thoroughly investigated within five days. This will monitored by the QA Specialist.	7 -23-10
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of incident reports and investigations, the facility failed to ensure that all allegations of neglect and injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of three clients included in the sample. (Client #1) The findings include: 1. On July 1, 2010, at approximately 11:30 a.m., the qualified mental retardation professional	W 153	See W 104 #3 See W 127	7-23-10 7-23-10

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W 153	Continued From page 12 provided the surveyor with an incident/investigative report dated May 15, 2010. According to incident/investigative report, Client #1 was not feeling well (Vital signs 97.6 - 96 - 20 and B/P 102/50). Further review of the incident/investigative report revealed the client's blood sugar level was elevated, she refused to eat dinner, and had one brown liquid stool. The primary care physician was called and ordered the client to be sent to the emergency room for further evaluation. Client #1 was transported via the facility's van to the emergency room. Shortly after arriving to the emergency room, Client #1 had expired. HRLA was not notified of this incident. 2. On July 1, 2010, at approximately 10:20 a.m., review of a nursing progress note dated August 17, 2009, revealed scratches were noted to the upper right arm etiology unknown. Interview with Nurse Coordinator (NC) on July 2, 2010, at approximately 3:50 p.m., revealed that she was not made aware of this incident (scratches) to Client #1's upper right arm. Review of the incident report log book on June 30, 2010, beginning at approximately 1:50 p.m., revealed there was no incident report generated for this incident. There was no evidence the facility reported the injury of unknown origin immediately to the administrator and DOH. 3. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated October 18, 2009 revealed Client #1 informed the nurse that she had a bruise on her stomach. The nurse observed a bruised area on the lower side of the	W 153	See W 331 2. See W 104 #3. 3. See W 104 #3.	7-23-10 7-23-10 7-23-10

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W 153	Continued From page 13 client's abdomen. Interview with Nurse Coordinator (NC) on July 2, 2010, at approximately 4:00 p.m., revealed that an incident report was generated for this incident. At the time of the survey however, there no incident report located in the incident report log book reviewed on June 30, 2010. On July 2, 2010, at approximately 6:14 p.m., an incident report dated October 18, 2009, was faxed to HRLA. The incident report revealed that the nurse and the qualified mental retardation professional were the only staff notified of the incident. There was no evidence the facility reported the injury of unknown origin immediately to the administrator and DOH. 4. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated April 10, 2010 revealed Client #1 showed the PM nurse her left hand, 3rd finger which was bruised. Interview with Nurse Coordinator (NC) on July 2, 2010, at approximately 4:10 p.m., revealed that an incident report was generated for this incident. At the time of the survey however, there no incident report located in the incident report log book reviewed on June 30, 2010. On July 2, 2010, at approximately 6:14 p.m., an incident report dated April 14, 2010, was faxed to HRLA. The incident report revealed that the Nurse and the qualified mental retardation professional were the only staff notified of the incident. There was no evidence the facility reported the injury of unknown origin immediately to the	W 153	4. See W 104 #3.	7-26-10

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W 153	Continued From page 14 administrator and DOH.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin and/or incidents of neglect, for one of three clients included in the sample. (Client #1) The findings include: On June 30, 2010, at approximately 2:30 p.m., the qualified mental retardation professional (QMRP) stated that facility policies required that all injuries of unknown origin must be investigated. On July 1, 2010, beginning at 10:00 a.m., review of Client #1's nursing progress notes revealed the following injuries of unknown origin: a. Cross refer to W153.3. On July 1, 2010, at approximately 10:20 a.m., review of a nursing progress note dated August 17, 2009 revealed scratches were noted to the upper right arm etiology unknown. There was no evidence that an investigaton was conducted related to the injury. b. Cross refer to W153.4. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated October 18, 2009 revealed Client #1 informed the nurse that she had a bruise on her stomach. The nurse observed a	W 154	See W 149 #4.	7-23-10

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W 154	Continued From page 15 bruised area on the lower side of the client's abdomen. There was no evidence that an investigaton was conducted related to the injury. c. Cross refer to W153.5. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated April 10, 2010 revealed Client #1 showed the evening nurse her left hand, 3rd finger which was bruised. There was no evidence that an investigaton was conducted related to the injury. Interview with the Nurse Coordinator on July 2, 2010, at approximately 4:00 p.m., revealed that she was not able to locate investigative reports for the above aforementioned incidents.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for one of three clients included in the sample. (Client #2) The finding includes: Cross Refer to W189. The facility's QMRP failed to ensure that the staff was provided with effective training that enabled the employee to perform his or her duties effectively, efficiently,	W 159	The management of MarJul Homes will ensure that the QMRPs will coordinate, integrate, and monitor services to all individuals. The QMRPs will be monitored by the Quality Assurance Specialist to ensure that all employees are able to perform their duties effectively, efficiently, and competently.	7-26-10

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W 159	Continued From page 16 and competently.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff two of four direct care staff on duty were effectively trained on implementing Client #2's mealtime protocol. (Staffs #6 and #9) The finding includes: On 6/30/10, at 5:34 p.m., observations of the dinner meal revealed Client #2 completed 100% of her food and beverage which consisted of baked turkey, sweet potatoes, turnip greens, pear halves, bread, and beverage. At 5:37 p.m., Client #2 was observed scrapping her plate/bowl for more food while Staff #6 sat right next to her and Staff #9 sat directly across from her. At no time did Staff #6 or #9 offer seconds to Client #2. Interview with Staffs #6 and #9 on the same day at approximately 5:45 p.m., revealed that they both had received training on food preparation and all mealtime protocols. Review of Client #2's current physician's orders dated June 2010, on July 1, 2010, at approximately 2:30 p.m., revealed Client #2 had a diagnosis of history of weight loss. Further review of the physician's orders revealed Client #2 was prescribed a "regular diet - increase fiber - bite	W 189	All staff will be retrained by the nutriitionist on implementing mealtime protcol and each specific individuals diet competently. Monitoring will be provided by the House Manager and the QMRP.	7-26-10

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W 189	Continued From page 17 sized pieces - offer seconds". Review of the facility's in-service training records on July 2, 2010, at approximately 3:50 p.m., revealed that all staff had received nutritional training on May 30, 2010. There was no evidence that training had been effective.	W 189		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that systems were designed and implemented to make certain clients were not subjected to neglect [See W127]; facility failed to provide routine testing as determined necessary by the primary care physician [See W322]; and failed to provide timely and appropriate nursing services with posed an immediate risk to Client #1's health and safety needs [See W331]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	See W 331 See Attachment #6	7-23-10
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 325		

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W 325	Continued From page 18 failed to provide routine testing as determined necessary by the primary care physician (PCP), for one (1) of three (3) clients included in the sample. (Client#1) The finding includes: On July 1, 2010, at approximately 8:00 p.m. , review of Client#1's records revealed a Physician Order Form dated May 2010 in which the PCP ordered an EKG every six months (starting August 20,2008). Further review of the record revealed a document from "Division of Cardiology at Georgetown University Hospital" dated August 5, 2009 which indicated that a EKG had been performed in April 2009. There was no documented evidence that an EKG had been performed every six months as ordered by the PCP. During a face to face interview with the Nurse Coordinator on July 1, 2010, at approximately 8:30 p.m., she acknowledged the finding. She stated the order was incorrect and the facility only got EKG's once a year.	W 325	The administration of MarJul Homes recognizes the need for the agency to go in a new direction. As a result we have hired an extremely competent Registered Nurse who is functioning as our Director of Nursing and we also have hired a new Primary Care Physician who has agreed to visit each facility monthly and to work very closely with our Director of Nursing to ensure that the individuals served by MarJul Homes received comprehensive and optimal healthcare at all times.	7-23-10
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide timely and appropriate nursing services which posed an immediate risk to Clients' health and safety for five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5)	W 331		

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W 331	Continued From page 19 The findings include: On July 1, 2010, surveyors identified an immediate jeopardy to clients health and safety. At approximately 2:23 p.m., the facility's administrator was notified by telephone that the safety concerns of the nursing services provided to Client #1 posed an immediate jeopardy to the other client's in the home. A. LPN#1/ Supervisor failed to provide nursing services in accordance with changes in Client # 1's mental health status as evidenced by the following: 1. Review of Client #1's record on July 1, 2010, at approximately 10:00 a.m., revealed a nursing note; dated May 15, 2010, timed 8:00 a.m. written by LPN #1. The nursing note reflects that Client #1 " appears to be weak and lethargic...Fasting Blood Sugar 268, Blood Pressure 138/80, Temperature 97.6, Pulse 88, and Respiration 18". The note indicated that client denied any pain or discomfort, and wanted to stay in bed. The note also indicated that the nurse would encourage fluids and continue to monitor the client. The nurse also documented that the LPN Nurse Coordinator was made aware of the client's health status. There was no evidence that the nurse provided fluids or continued to monitoring the patient. 2. Interview with LPN#1/ Supervisor revealed that she was unable to accurately assess Client #1's mental health status. During a face to face interview with	W 331	The administration at Marjul Homes acknowledges that there needs to be a comprehensive health preservation program that enurses follow up of medical conditions and oversight of nursing care. As of 7/23/2010 the following measures / actions have been put in place to enure the safety of our individuals, quality nursing care, and nursing oversight: 1) The administration has conducted a thorough investigation including interviews of all employees. 2) The LPN Med Nurses / LPN Coordinator / DCS that were directly involved with this situation have been placed on suspension. 3) The previous RN was replaced with another RN. 4) After assessment of health services a RN Plan of Correction was developed and instituted. See attached. 5) The services of a new PCP have been secured to improve health care services. 6) Monitoring tools have been put in place and a Quality Assurance Specialist has been added to the team and will be working closely with all management. 7) The Nursing department has been assessed and interviews are being conducted to assist with restructuring of the Nursing Department to increase the Nurse / Individual ratio. 8) Monthly Nursing meetings will take place to assist with education, communication and documentation improvement. 9) An ongoing approach to reviewing policy / procedures as it pertains to the ever changing needs of our individuals has been instituted to ensure a proactive approach rather then a reactive approach to providing comprehensive care.	7-23-10

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W 331	Continued From page 20 LPN#1/Supervisor on July 1, 2010, at approximately 12:40 p.m., it was revealed that she was informed by DCS #1 on May 15, 2010, that Client #1 was not feeling well. LPN #1 assessed the client by taking her vital signs and getting a blood sugar. Although LPN#1/Supervisor documented in her nursing note on May 15, 2010, that the client appeared weak and lethargic, she stated that the client was alert, oriented to person, place and time. The client was able to follow command and did not look any different than normal. LPN#1/Supervisor was then asked to define weak and lethargic as written in the aforementioned nursing note. The nurse stated that weak meant " the client would not get up " and lethargic meant " weak ". There was no evidence that LPN#1/Supervisor was able to accurately assess client as evidenced by information obtained from interview and nursing documentation. 3. Interview with LPN #1/Supervisor revealed that she failed to inform the facility's physician of changes in Client #1 mental health status as evidenced by the following: Although the LPN #1/Supervisor documented that Client #1's vital signs and blood sugar were as follows: Temperature 97.06, Pulse 88, Respiration 18, Blood Pressure 138/80 and Blood Sugar 268, she assessed the client as "lethargic, weak and indicated that the client refused to get out of bed. "She failed to report the change in the client's health status to the facility's primary physician.	W 331		

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Further interview with LPN#1/Supervisor acknowledged that she had informed the Nurse Coordinator (NC) of her findings, but not the physician.

There was no documented evidence that the physician was made aware of the change in Client #1's mental health status.

4. LPN #1/Supervisor failed to provide appropriate and adequate instructions for Direct Care Support (DCS) to monitor client.

Continued face to face interview, revealed that LPN #1/Supervisor indicated that she instructed DCS staff to monitor client and to call the NC if Client #1 did not eat or get out of bed. Further interview revealed that she did not instruct DCS on the frequency of how often to monitor Client #1.

There was no documented evidence that the nurse had instructed the DCS staff on signs and symptoms of hyper or hypoglycemic reactions or other medical concerns as it related to Client#1.

B. On July 1, 2010, at approximately 1:00 p.m., interview with the Nurse Coordinator (NC) revealed that she failed to inform facility's physician and the Director of Nursing of changes in Client #1's mental health status as evidence by the following:

1. The NC indicated at approximately 8:00 a.m., on May 15, 2010, LPN#1/ Supervisor called to inform her that Client #1 was not feeling well and did not want to get out of bed. The NC was told that the client's vital signs were stable, but her blood sugar (per finger stick) was elevated.

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Due to the elevated blood sugar reading, LPN #1/Supervisor gave the routinely prescribed coverage for the elevated blood sugar level. The NC did not inform the physician nor was there any evidence taht the NC conducted her own assessment of client #1 as she indicated.

2. The NC indicated that she called the home at 11:00 a.m. on May 15, 2010, and spoke with a DCS member. She was told by the staff that Client #1 was fine. She instructed the DCS to encourage water and not to give the client juice because of her elevated blood sugar. There was no documented evidence, however, of her phone call or instruction to DCS in the client records.

C. The facility's nursing services failed to ensure acute/emergency nursing care in accordance with Client#1's needs as evidenced below:

1. DCS #3 reported during an interview on July 1, 2010 that LPN #2 arrived to the facility at approximately 5:30 p.m. to administer medications. Although, upon the LPN's arrival, DCS #3 made her aware that Client #1 was not feeling well, the LPN did not observe the client at that time, and proceeded to administer medications to Client #2 and Client #3. After the LPN completed the medication pass for these two clients, she went upstairs to check on Client #1. The facility's internal investigation revealed that DCS #3 noticed at that time that the client's bed sheets were soiled with fecal matter. DCS #3 informed the LPN that it was unusual for the client to soil her sheets and that she needed medical attention. DCS #3 indicated that she and DCS #2 helped to ambulate the Client to the bathroom for a sponge bath. DCS #3 indicated that the client could not walk independently because of her

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unsteady gait. According to interviews, both DCS #2 and #3 stood on each side of the client and provided total assistance to and from the bathroom. It should be noted that this client had been independent with toileting prior to this incident. The nurse assessed the client ' s vital signs and blood sugar, and then called the Nurse Coordinator (NC).

2. During a face to face interview with the Nurse Coordinator (NC) on July 1, 2010, at approximately 1:00 p.m., the NC indicated that LPN #2 called to report the client ' s condition at 7:00 p.m. [the time of 7:00 is not consistent with the facility's internal investigation that reported the time to be 6:00 p.m.]. The LPN asked the NC to call Client #1's physician because the client refused dinner and continued not to feel well. The NC indicated that LPN #2 reported the client's vital signs and blood sugar [temperature was 97.6, pulse 96, respiration 20, blood pressure 102/58, blood sugar 324]. It should be noted that LPN #2 did not report the client ' s unsteady gait to the NC. The LPN indicated, in her interview with surveyors, that although the client had a large liquid brown stool, the client walked independently to the bathroom and appeared not to be in any distress.

3. The NC indicated that after she was informed by LPN #2, she contacted Client #1's physician and reported that the client was not feeling well and refusing to eat dinner. The physician then ordered that the client be sent to the emergency room for evaluation. However, there was no documented evidence of the telephone order or NC's conversation with the physician. The NC also could not recall the time of the telephone discussion with the physician. Additionally, there

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was no documented evidence that the NC made arrangements for the client to be transported to the emergency room. [It should be noted that there has been several unsuccessful attempts to interview the facility's primary physician.]

4. Interview with the QMRP and the review of the facility's internal investigation revealed that the NC made arrangements for the residential van to transport Client #1 to the emergency room. The NC was questioned by the surveyors as to her decision to transport Client #1 to the emergency room utilizing the residential vehicle instead of calling 911 while knowing that there was a decrease of 20 degree in the client's blood pressure. She responded by saying, "normally I only call 911 when the client is unresponsive, other than that, they go to the emergency room by van".

D. The facility nursing staff failed to ensure that Client #1 was supervised by nursing personnel during an acute medical illness.

1. After receiving the physician's telephone orders to transport the client to the emergency room, LPN #2 administered Client #1's evening medications. LPN #2 then contacted the NC to inform her that the van driver had not arrived to transport the client to the Emergency Room. LPN #2 stated that the driver, who was working at another facility, could not leave to transport the client until there was staffing coverage. LPN #2 informed the NC that she was leaving the facility to provide the staff coverage so that the driver could leave to transport the client to the ER. She left the client without any nursing or medical

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MARJUL HOMES	1639 ROXANNA ROAD, NW WASHINGTON, DC 20012

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supervision or instruction to the staff as to emergency interventions.

2. Interview with the van driver revealed that upon his arrival to the facility, Client #1 was sitting in a chair in her bedroom. He also revealed that the client ' s gait was unsteady as he needed the assistance of DSC #2 to ambulate her to the van. He further added that the staff had to provide assistance to position the client in the van seat. DCS #3 confirmed the driver's observation and added that the client was slumped over as DCS #2 and the driver escort her to the van.

3. The van driver indicated that the client just sat quietly on the ride to the hospital. Upon arrival to the hospital, at approximately 9:11 p.m., the client, needed total assistance from the driver and hospital personnel (2) to transfer from the van to the wheelchair. The hospital records revealed that the client presented slumped over in the wheelchair; with blood tinged vomitus drooling from her mouth and not responding to verbal or painful stimuli. The client was placed in code room and on a cardiac monitor. A pulse was not detected. Cardiopulmonary Resuscitation (CPR) was started.

4. The chief complaint/quote "Staff reports patient (Client #1) has nausea, vomiting and diarrhea since this am". Also the triage nurse documented that during triage he was unable to get a blood pressure or pulse. Patient was rushed to the code room placed on the monitor and CPR was started."

5. It was further revealed that CPR was initiated at 9:27 p.m. and stopped at 9:51 p.m. per a document entitled " Code Blue Form".

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6. Further review of the ER document, revealed the emergency room physician documented "According to staff member, patient (Client #1) vomiting and weak since this morning. Patient brought in by van without pulse. "

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I 000	Continued From page 1	I 000		

1. A Management of Medical Emergencies Protocol describing instructions for emergency instructions will be developed immediately.

2. Staff training on above Management of Medical Emergencies Protocol will occur immediately.

3. All staff will be trained on Management of Medical Emergencies Protocol within 24 hours with the first training to begin today (7/1/2010). As of 7:35 p.m. on 7/1/2010 all staff have been trained on this protocol. All staff will be trained weekly x 4 weeks, then monthly x 4, then quarterly.

4. The Licensed Practical Nurses (LPN) that were identified have been removed from active duty and will receive training and be required to demonstrate competency on the following (7/2/2010) prior to returning to active status. A Pre / Post test will be administered. The LPN's will be trained weekly x 4 weeks, then monthly x 4, then quarterly.

a. Management of Emergency Medical Conditions

b. Assessment of Medical Status, Abnormal Conditions

c. Identifying an Emergency

d. Notification / Follow Up of Emergencies

e. Documentation

5. A monitoring tool will be developed and implemented to ensure that assessments and

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I 000	Continued From page 2 follow up services are being completed / documented. Monitoring frequency will begin at every other day and be decreased as competency /completion is demonstrated. 6. Health Management Care Plan's will be reviewed / updated and training of all staff will occur within 72 hours. 7. A Policy establishing RN assessment of all individuals with changes in medical status to occur within 24 hours based on individual's needs (stability) will be implemented. The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports. As a result, the facility was deemed in non-compliance with the Conditions of Participation in the areas of Client Protections and Health care services.	I 000		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that a resident with a modified diet had been reviewed at least quarterly by the consulting dietitian, for one of the three residents included in the sample. (Residents #1) The findings include:	I 058		

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I 058	Continued From page 3 Review of Resident #1's current physician orders (POS) dated May 2010, on July 1, 2010, at 4:00 p.m., revealed a diet order of 1200 calorie, low cholesterol, no added salt, no concentrated sweets, bite size pieces. Further review of the medical record revealed that there was no documented evidence that the dietician had conducted a quartely review of the resident's diet for February 2010. During a face to face interview with the QMRP on July 1, 2010 at approximately 4:30 p.m., the finding was acknowledged.	I 058	The administration of MarJul will ensure that all consultants complete their contractual obligations or the administration will terminate the contracts.	7-27-10
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMR P failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, The findings include: Observation and interview with the facility's House Manager on July 1, 2010, beginning at 11:30 a.m. revealed the following: Exterior: 1. The front walkway was cracked on the upper landing near the front door.	I 090	The administration of MarJul Homes will ensure that the interior and exterior of the facility is maintainedin a safe, orderly attractive and sanitary manner. The House Managers will be retrained on their responsibility and monitored by the QA specialist and the QMRP. See Attachment # 7 Repair completed	7-27-10 7-27-10

Health Regulation Administration

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I 000	INITIAL COMMENTS A recertification survey was conducted from June 30, 2010 through July 2, 2010. A sample of three clients was selected from a population of five females with varying degrees of intellectual disabilities. While assessing the facility's incident managment system, the surveying team reviewed an incident where Client #1 was transported to a local hospital's emergency room for evaluation after complaining of not feeling well and having elevated blood sugar and a low blood pressure. A review of the internal investigation revealed that the client died shortly after arriving to the emergency room. Due to the nature of this incident and due to the facility's failure to report the incident to the SSA, an investigation commenced on July 1, 2010 and was completed on July 2, 2010. This survey/investigation was initiated utilizing the fundamental process; however, due to concerns in the area healthcare, the process was extended on July 1, 2010, at approximately 12:50 p.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Health Care Services and Client Protection. The extension led to the determination that the facility's nursing practice posed an immediate and serious threat to clients residing in the facility. The agency's administrator and the Director of Nursing (DON) were notified on the same at approximately 2:23 p.m. of the Immediate Jeopardy (IJ) to client's health and safety. The IJ was lifted later that day, at approximately 7:40 p.m., after the facility submitted a credible plan of action to address the client's immediate, short term and long term safety outlined below:	I 000	See W 331	7-23-10

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I 090	Continued From page 4	I 090		
	2. There were tree branches observed on the front roof over the door.		Repair completed	7-27-10
	3.The front and rear yard both have bare soil.		Sod has been applied to the front and rear yard.	
	4. Chipping and peeling paint on bottom of the front entrance door.		Repair completed	7-27-10
	5. Metal trim on entrance door frame cut and exposed which could cause potential danger to anyone entering the facility through the front door.		Repair completed	7-27-10
	Rear Exterior of House:			
	1. The rear cement deck has excessive tree limbs on it,		Repair completed	7-27-10
	2. A number of the treas are leaning toward the house and are rotten and have potential to fall on side of house, and there are tree branches on the rear roof over the house.		Trees removed	7-19-10
	3. There was observed in the rear and front yard a number of chipmonks, I informed animal control of this situation and was informed they pose no threat to the safety of the residents or staff.			
	Interior:			
	1. In inspecting the attic I found water stained ceiling tiles and blistering pockets.		Repair completed	7-27-10
	In the attic bathrom there is torn wall paper over the sink.			
	3. There is a dresser knob, and light cover, and light globe on the ledge over the steps.		Repair completed	7-27-10
	4. In Resident #1, bedroom in the rear of the			

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I 090	Continued From page 5	I 090		
	second floor there are dead bugs on the ceiling lens.		Repair completed	7-27-10
	5 .In Residents #4 and #5s bedroom the third drawer of the dresser has a piece missing. In the bathroom of the same roomthere are broken veneitan blinds. Caulking around the shower is dirty, and he floor drain has rust around it. Also in there bathroom there is no cup holder or cups.		Repair completed	7-27-10
	6.In the Kitchen the freezer is broken and there are no thermostats in the refrigerator or freezer. Hamberger in the refrigerator appears to have been freezer burned and the House was informed that it should be removed .		Repair completed	7-27-10
	7.The kitchen light switch does not turn lights on and off, and the light over the sink does not work, and the ceiling light over the stove doeas not work.		Repair completed	7-27-10
	8. The first floor bathroom sink water empties slow.		Repair completed	7-27-10
	9. There is chipping and peeling paint on the wall unthe hood over the stove., and the trash can top is rusty.		Repair completed	7-27-10
	The House Manager acknowledged the above-cited deficiencies at the conclusion of the environmental survey at approximately 12:30 p. m.			
I 165	3507.4(c) POLICIES AND PROCEDURES	I 165		
	The manual shall incorporate policies and procedures for at least the following:			
	(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and			

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I 165	Continued From page 6 procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on interview and record review the Group Home for Mentally Retarded Person's (GHMRP) failed to develop policies and procedures which addressed emergency transfer of a resident to the emergency room for an evaulation of an acute illness for five (5) of five (5) resident's. The finding includes: On July 1, 2010 at approximately 11:30 a.m., a face to face interview with the Director of Nursing (DON) revealed that the only emergency policy the group home had a was entilted "Adverse Reaction: Reporting and Follow-up" Review on the aforementioned policy on July 1, 2010 at approximately 12:45 pm, revealed that the policy failed to address an emergency transfer of a resident to the emergency room for an evaulation of an acute illness. There was no documented evidence of an Emergency Policy addressing emergency transfer of a resident to the emergency room for an evaulation of an acute illness. (See Federal Deficiency Report Citation W149)	I 165	See W 331	7-23-10
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by:	I 189		

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I 189	Continued Frdm page 7 Based on staff interview and record review, the GHMRP failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for two of the five clients residing in the GHMRP. (Clients #3 and #4) The findings include: 1. On July 2, 2010, at approximately 3:20 p.m., interview with the qualified mental retardation professional (QMRP) and review of the client's financial records revealed that the GHMRP assisted the client's with maintaining her finances. Review of Resident#3's bank statement dated April 2, 2010, revealed a withdrawal in the amount of $300.00. Further review of the client's financial failed to provide receipts withdrawals/expenditures from Resident#3's personal account. This was acknowledged through interview with the QMRP on the same day at approximately 3:35 p.m. At the time of the survey, the GHMRP failed to ensure a complete accounting of the client's personal funds by proving evidence that justified the aforementioned withdrawal. 2. Interview with the QMRP on July 2, 2010, at approximately at 3:45 p.m., and review of Resident#4's financial record, revealed that the GHMRP assisted the Residentwith maintaining her finances. Review of the Resident#4's records revealed 300.00 was withdrawn from her account on April 8, 2010, and 50.00 was withdrawn from her account on May 7, 2010. Further review of the client's financial failed to provide receipts withdrawals/expenditures from Resident#3's	I 189	See W 140-1 See W 140-1	7-28-10 7-28-10

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I 189	Continued From page 8 personal account. This was acknowledged through interview with the QMRP on the same day at approximately 4:00 p.m. At the time of the survey, the GHMRP failed to ensure a complete accounting of the client's personal funds by proving evidence that justified the aforementioned withdrawal.	I 189		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on personnel record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure current health screening for one of fourteen employees (#10) and two of six constultants, the psychlogist (#4) and one LPN (#5). The finding includes: During a record review and interview with the House Manager on July 1, 2010, at approximately 2:30 p.m. revealed that a direct care staff (#10a) and two consultant staff did not have a current health screening on file. These findings were acknowledged by the House Manager at the time of the record review.	I 206	CPR, first aid, health screenings and background screenings will be completed as conditions of employment . No one will on the schedule without these required documents.	7-26-10

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I 222	Continued From page 9	I 222		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure Staff 2 of 4 direct care staff on duty was effectively trained on implementing Resident #2's mealtime protocol. (Staffs #6 and #9) The finding includes: On 6/30/10, at 5:34 p.m., observations of the dinner meal revealed Resident #2 completed 100% of her food and beverage which consisted of baked turkey, sweet potatoes, turnip greens, pear halves, bread, and beverage. At 5:37 p.m., Resident #2 was observed scrapping her plate/bowl for more food while Staff #6 sat right next to her and Staff #9 sat directly across from her. At no time did Staffs #6 and #9 "offer seconds" to resident#2. Interview with Staffs #6 and #9 on the same day at approximately 5:45 p.m., revealed that they both had received training on food preparation and all mealtime protocols. Review of Resident#2's current physician's orders dated June 2010, on July 1, 2010, at approximately 2:30 p.m., revealed Resident #2 had a diagnosis of history of weight loss. Further review of the physician's orders revealed Resident #2's was prescribed a "regular diet - increase fiber - bite sized pieces - offer seconds". Review of the GHMRP's in-service training records on July 2, 2010, at approximately 3:50	I 222	See W 189	7-27-10

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I 222	Continued From page 10 p.m., revealed that all staff had received nutritional training on May 30, 2010. There was no evidence that training had been effective.	I 222		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for three of the fourteen staff (Staff #2, #6 and #10), and current training in first aid, for four of the fourteen staff (Staff #2, #6, #10, and # 12). The finding includes: Review DF the personnel and training records on July 1, 2010, beginning at 2:30 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for three of the fourteen staff (Staff #2, #6 and #10) and training in first aid, for fDur of the fourteen staff (Staff #2, #6, #10 and #12).	I 227	See I 206	7-26-10
I 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situatiDns, including fire or general disaster, missing	I 370		

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I 370	Continued From page 11 persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on interview and record review the Group Home for Mentally Retarded Person's (GHMRP)failed to develop policies and procedures which addressed emergency situations including serious illnesses for five (5)of five (5) resident's. The finding includes: On July 1, 2010 at approximately 11:30 a.m., a face to face interview with the Director of Nursing (DON) revealed that the only emergency policy the group home had was entilted "Adverse Reaction: Reporting and Follow-up". Further interview revealed that a written policy had not been developed to address the management of medical emergencies protocol describing instructions for emergency instructions. Review of the aforementioned policy on July 1, 2010, at approximately 12:45 p.m., revealed that the policy failed to address emergency situations related to serious illnesses. There was no documented evidence of an Emergency Policy addressing serious illness.	I 370	See W 331	7-23-10
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within	I 379		

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I 379	Continued From page 12 twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of three residents included in the sample. (Resident #1) The finding includes: 1. On July 1, 2010, at approximately 11:30 a.m., the qualified mental retardation professional provided the surveyor with an incident/investigative report dated May 15, 2010. According to incident/investigative report, resident #1 was not feeling well (Vital signs 97.6 - 96 - 20 and B/P 102/50). Further review of the incident/investigative report revealed the resident blood sugar level was elevated, she refused to eat dinner, and had one brown liquid stool. The primary care physician was called and ordered the resident to be sent to the emergency room for further evaluation. resident #1 was transported via the GHMRP's van to the emergency room. Shortly after arriving to the emergency room, resident #1 had expired. HRLA was not notified of this incident. 2. On July 1, 2010, at approximately 10:10 a.m., review of a nursing progress note dated August 3, 2009 revealed resident #1 stated to the PM Nurse that she had fallen out of the van. The nurse assessed resident #1 as having broken skin to both of her knees. Interview with Nurse	I 379	See W 331	7-23-10

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I 379	Continued From page 13 Coordinator (NC) on July 2, 2010, at approximately 3:45 p.m., revealed that an incident report was generated for this incident. However, there no incident report located in the incident report log book reviewed on June 30, 2010. On July 2, 2010, at approximately 5:59 p.m., an incident report dated August 31, 2009, was faxed to HRLA. The incident report revealed that the nurse was the staff person notified of the incident. There was no evidence the GHMRP reported the injury of unknown origin immediately to the administrator and DOH. 3. On July 1, 2010, at approximately 10:20 a.m., review of a nursing progress note dated August 17, 2009, revealed scratches were noted to the upper right arm etiology unknown. Interview with Nurse Coordinator (NC) on July 2, 2010, at approximately 3:50 p.m., revealed that she was not made aware of this incident (scratches) to resident #1's upper right arm. Reviewed of the incident report log book on June 30, 2010, beginning at approximately 1:50 p.m., revealed there was no incident report generated for this incident. There was no evidence the GHMRP reported the injury of unknown origin immediately to the administrator and DOH. 4. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated October 18, 2009 revealed resident #1 informed the nurse that she had a bruise on her stomach. The nurse observed a bruised area on the lower side of the resident's abdomen. Interview with Nurse	I 379		

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I 379	Continued From page 14 Coordinator (NC) on July 2, 2010, at approximately 4:00 p.m., revealed that an incident report was generated for this incident. However, there no incident report located in the incident report log book reviewed on June 30, 2010. On July 2, 2010, at approximately 6:14 p.m., an incident report dated October 18, 2009, was faxed to HRLA. The incident report revealed that the nurse and the qualified mental retardation professional were the only staff notified of the incident. There was no evidence the GHMRP reported the injury of unknown origin immediately to the administrator and DOH. 5. On July 1, 2010, at approximately 10:30 a.m., review of a nursing progress note dated April 10, 2010 revealed resident #1 showed the PM nurse her left hand, 3rd finger which was bruised. Interview with Nurse Coordinator (NC) on July 2, 2010, at approximately 4:10 p.m., revealed that an incident report was generated for this incident. However, there no incident report located in the incident report log book reviewed on June 30, 2010. On July 2, 2010, at approximately 6:14 p.m., an incident report dated April 14, 2010, was faxed to HRLA. The incident report revealed that the Nurse and the qualified mental retardation professional were the only staff notified of the incident. There was no evidence the GHMRP reported the injury of unknown origin immediately to the administrator and DOH.	I 379		

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I 401	Continued From page 15	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the Group Homes for Mentally Retarded Persons (GHMRP) failed to provide timely and appropriate nursing services which posed an immeidate risk to Resident #1's health and safety. The findings include: On July 1, 2010, Surveyors identified an immediate jeopardy to the Residents health and safety. At approximately 2:23 p.m., the GHMRP's administrator was notified by telephone that the safety concerns of the nursing services provided to Resident #1 posed an immediate jeopardy to the other resident's in the home. A. LPN#1/ Supervisor failed to provide nursing services in accordance with changes in Resident # 1's mental health status as evidenced by the following: 1. Review of Resident #1's record on July 1, 2010, at approximately 10:00 a.m., revealed a nursing note; dated May 15, 2010, timed 8:00 a.m. written by LPN #1. The nursing note reflects that Resident #1 " appears to be weak and lethargic...Fasting Blood Sugar 268, Blood Pressure 138/80, Temperature 97.6, Pulse 88, and Respiration 18". The note indicated that	I 401	See W 331	7-23-10

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resident denied any pain or discomfort, and wanted to stay in bed. The note also indicated that the nurse would encourage fluids and continue to monitor the resident. The nurse also documented that the Nurse Coordinator was made aware of the resident's health status.

There was no evidence that the nurse provided fluids or continued to monitor the resident.

2. Interview with LPN#1/ Supervisor revealed that she was unable to accurately assess Resident #1's mental health status.

During a face to face interview with LPN#1/Supervisor on July 1, 2010, at approximately 12:40 p.m., it was revealed that she was informed by DCS #1 on May 15, 2010, that Resident #1 was not feeling well. LPN #1 assessed the resident by taking her vital signs and getting a blood sugar. Although LPN#1/Supervisor documented in her nursing note on May 15, 2010, that the resident appeared weak and lethargic, she stated that the resident was alert, oriented to person, place and time. The resident was able to follow command and did not look any different than normal.

LPN#1/Supervisor was then asked to define weak and lethargic as written in the aforementioned nursing note. The nurse stated that weak meant " the resident would not get up " and lethargic meant " weak ".

There was no evidence that LPN#1/Supervisor was able to accurately assess Resident #1 as evident by information obtained from interview and nursing documentation.

3. Interview with LPN #1/Supervisor revealed that

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I 401	Continued From page 17 she failed to informed facilities physician of changes in Resident #1 mental health status as evidence by the following: Although the LPN#1/Supervisor documented that Resident #1's vital signs and blood sugar were as follows: Temperature 97.06, Pulse 88, Respiration 18, Blood Pressure 138/80 and Blood Sugar 268, she assessed the Resident as "lethargic, weak and indicated that the Resident refused to get out of bed. "She failed to report the change in the resident's health status to the facilities primary physician. Further interview LPN#1/Supervisor acknowledged that she had informed the Nurse Coordinator (NC) of her findings, but not the physician. There was no documented evidence that the physician was made aware of the change in Resident #1's mental health status. 4. LPN#1/Supervisor failed to provide appropriate and adequate instructions for DCS to monitor Resident #1. Continued face to face interview, revealed that LPN#1/Supervisor indicated that she instructed DCS staff to monitor Resident #1 and to call the NC if Resident #1did not eat or get out of bed. Further interview revealed that she did not instruct DCS on the frequency of how often to monitor Resident #1. There was no documented evidence that the nurse had instructed the DCS staff on signs and symptoms of hyper or hypoglycemic reactions or other medical concerns as it related to Resident #1.	I 401		

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B. On July 1, 2010, at approximately 1:00 p.m., interview with the Nurse Coordinator (NC) revealed that she failed to informed facilities physician of changes in Resident #1 mental health status as evidence by the following:

1. The NC indicated at approximately 8:00 a.m., on May 15, 2010, LPN#1/ Supervisor called to inform her that Resident #1 was not feeling well and did not want to get out of bed. The NC was told that the resident's vital signs were stable, but her blood sugar (per finger stick) was elevated. Due to the elevated blood sugar reading, LPN #1/Supervisor gave the routinely prescribed coverage for the elevated finger stick. The NC did not inform the physician of LPN#1/Supervisor's findings; however, she admitted that she informed LPN#1/Supervisor that she would check on Resident #1. However, there was no evidence that the NC visited the resident to conduct her own assessment.

2. The NC indicated that she called the home at 11:00 a.m. on May 15, 2010, and spoke with a DCS member. She was told by the staff that Resident #1 was fine. She instructed the DCS to encourage water and not to give the resident juice because of her elevated blood sugar. There was no documented evidence, however, of her phone call or instruction to DCS in the Resident records.

C. The GHMRP's nursing services failed to ensure acute/emergency nursing care in accordance with Resident #1's needs as evidenced below:

1. DCS#3 reported during an interview on July 1, 2010 that LPN#2 arrived to the GHMRP at

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I 401	Continued From page 19 approximately 5:30 p.m. to administer medications. Although, upon the LPN's arrival, DCS #3 made her aware that Resident #1 was not feeling well, the LPN did not observe the resident at that time, and proceeded to administer medications to Resident #2 and Resident #3. After the LPN completed the medication pass for these two residents, she went upstairs to check on Resident #1. The GHMRP's internal investigation revealed that DCS #3 noticed at that time that the resident's bed sheets were soiled with fecal matter. DCS #3 informed the LPN that it was unusual for the resident to soil her sheets and that she needed medical attention. DCS #3 indicated that she and DCS #2 help to ambulate the resident to the bathroom for a sponge bath. DCS #3 indicated that the resident could not walk independently because of her unsteady gait. According to interviews, both DCS #2 and #3 stood on each side of the resident and provided total assistance to and from the bathroom. It should be noted that this Resident had been independent with toileting prior to this incident. The nurse assessed the resident ' s vital signs and blood sugar, and then called the Nurse Coordinator (NC). 2. During a face to face interview with the Nurse Coordinator (NC) on July 1, 2010, at approximately 1:00 p.m., the NC indicated that LPN#2 called to report the Resident ' s condition at 7:00 p.m. [the time of 7:00 is not consistent with the GHMRP's internal investigation that reported the time to be 6:00 p.m.]. The LPN asked the NC to call Resident #1's physician because the Resident refused dinner and continued not to feel well. The NC indicated that LPN #2 reported the Resident's vital signs and blood sugar [temperature was 97.6, pulse 96, respiration 20, blood pressure 102/58, blood	I 401		

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I 401	Continued From page 20 sugar 324]. It should be nDted that LPN #2 did not report the Resident ' s unsteady gait to the NC. The LPN indicated, in her interview with surveyors, that although the Resident had a large liquid brown stool, the Resident walked independently tD the bathroom and appeared not to be in any distress. 3. The NC indicated that after she was informed by LPN #2, she contacted Resident #1's physician and reported that the Resident was not feeling well and refusing to eat dinner. The physician then ordered that the Resident be sent to the emergency room for evaluation. However, there was no documented evidence of the telephone Drder or NC's conversation with the physician. The NC also could not recall the time of the telephone discussion with the physician. Additionally, there was no documented evidence that the NC made arrangement for the Resident to be transported to the emergency room. [It should be noted that there has been several unsuccessful attempts to interview the GHMRP's primary physician.] 4. Interview with the QMRP and the review of the GHMRP's internal investigation revealed that the NC made arrangements for the residential van to transport Resident #1 to the emergency room. The NC was questioned by the surveyors as to her decision to transport Resident #1 to the emergency room utilizing the residential vehicle instead of calling 911 while knowing that there was a decrease of 20 degree in the Resident's blood pressure. She responded by saying, "normally I only call 911 when the Resident is unresponsive, other than that, they go to the emergency room by van".	I 401		

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D. The GHMRP nursing staff failed to ensure that Resident #1 was supervised by nursing personnel during an acute medical illness.

1. After receiving the physician's telephone orders to transport the Resident to the emergency room, LPN#2 administered Resident #1's evening medications. LPN#2 then contacted the NC to inform her that the van driver had not arrived to transport the Resident to the Emergency Room. LPN #2 stated that the driver, who was working at another GHMRP, could not leave to transport the Resident until there was staffing coverage. LPN#2 informed the NC that she was leaving the GHMRP to provide the staff coverage so that the driver could leave to transport the Resident to the ER. She left the Resident without any nursing or medical supervision or instruction to the staff as to emergency interventions.

2. Interview with the van driver revealed that upon his arrival to the GHMRP, Resident #1 was sitting in a chair in her bedroom. He also revealed that the Resident ' s gait was unsteady as he needed the assistance of DSC #2 to ambulate her to the van. He further added that the staff had to provide assistance to position the Resident in the van seat. DCS#3 confirmed the driver's observation and added that the Resident was slumped over as DCS#2 and the driver escort her to the van.

3. The van driver indicated that the Resident just sat quietly on the ride to the hospital. Upon arrival to the hospital, at approximately 9:11p.m., the Resident, needed total assistance from the driver and hospital personnel (2) to transfer from the van to the wheelchair. The hospital records

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I 401	Continued From page 22 revealed that the Resident presented slumped over in the wheelchair; with blood tinged vomitus drooling from her mouth and not responding to verbal or painful stimuli. The Resident was placed in code room and on a cardiac monitor. A pulse was not detected. Cardiopulmonary Resuscitation (CPR) was started. 4. The chief complaint/quote "Staff reports patient (Resident #1) has nausea, vomiting and diarrhea since this am". Also the triage nurse documented that during triage he was unable to get a blood pressure or pulse. Patient was rushed to the code room placed on the monitor and CPR was started." 5. It was further revealed that CPR was initiated at 9:27 p.m. and stopped at 9:51 p.m. per a document entitled " Code Blue Form". 6. Further review of the ER document, revealed the emergency room physician documented "According to staff member, patient (Resident #1) vomiting and weak since this morning. Patient brought in by van without pulse. "	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the rights of residents were observed and protected in	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G221	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	1639 ROXANNA ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 23 accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws for five of five clients included in the survey. (Clients #1, #2, #3, #4, and #5) The finding includes: 1. § 7-1305.10. Mistreatment, neglect or abuse prohibited; use of restraints; seclusion; "time-out" procedures [Formerly § 6-1970] (e) Alleged instances of mistreatment, neglect or abuse of any customer shall be reported immediately to the Director and the Director shall inform the customer's counsel, parent or guardian who petitioned for the commitment, and the customer's mental retardation advocate of any such instances. There shall be a written report that the allegation has been thoroughly and promptly investigated (with the findings stated therein). Employees of facilities who report such instances of mistreatment, neglect, or abuse shall not be subjected to adverse action by the facility because of the report. The facility failed to provide evidence that all incidents of abuse, neglect or mistreatment, including injuries of unknown origin were reported timely and thoroughly investigated. [See Federal Deficiency Report - Citations W149, W153 and W154] 2. The facility failed to provide timely and appropriate nursing services and the severity of the failure posed an immediate risk to residents' health and safety. [See Federal Deficiency Report - Citation W331]	I 500	See W 105-a	7-27-10